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DEPARTMENT OF HEALTH FOR SCOTLAND

SCOTTISH HEALTH SERVICES COUNCIL

Mental Health Legislation

Second Report
by a Committee appointed
by the Council

EDINBURGH
HER MAJESTY'S STATIONERY OFFICE
1959
ONE SHILLING NET

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* Because of the pressure of other commitments, Mrs. Ewart was obliged to resign from the Committee in the course of their deliberations.

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Mental Health Legislation

SECOND REPORT

Introduction

1. Our present report follows on a decision made by the Scottish Health Services Council after receiving our first report last year. In this first report, dated March, 1958, we recorded our regret that lack of time had prevented us from devoting sufficient attention to the important question of community care for the mentally disordered. The Council, having been informed that more time was available for deliberation than at first had seemed likely, asked us to resume work in order to deal with this question fully, and at the same time invited Mrs. Allan, Dr. MacGillivray and Dr. Uytman to serve as additional members of the Committee. The present report is based on the conclusions contained in the first, and should be read in conjunction with it.

2. It may be helpful to re-state at this point the terms of reference which we were originally given by the Council. These were:

> "To consider the application to Scotland of the major recommendations in the Report of the Royal Commission on the Law relating to Mental Illness and Mental Deficiency in England and Wales (Cmnd. 169) in the light of the White Paper on the Law relating to Mental Illness and Mental Deficiency in Scotland (Cmd. 9623) and to make recommendations."

3. Since we embarked on the second stage of our work we have held 8 meetings. We decided that it would be helpful to us to hear at first hand about certain aspects of community care, and we therefore invited a number of people with appropriate practical experience to attend certain of our meetings. Their names appear in Appendix I to our report, and we would like to place on record our gratitude to them for giving us the benefit of their knowledge.

4. We are anxious that everything possible should be done to enable the mentally disordered person to enter into the life of the community as far as his disabilities will allow, and we have reached the conclusion that certain community services for the mentally disordered need to be extended—and sometimes created—in Scotland. We have at the same time tried to keep in mind the factors necessary to make up a balanced picture; these include the clinical needs of certain kinds of mental patient and the circumstances of Scottish geography. We will mention the effect of these factors later in our report.

Community services and allocation of functions

5. A very considerable range of services is needed if adequate provision is to be made for mentally handicapped people of all ages who either do not become hospital in-patients at all or who require care and help after discharge from hospital. We have kept in mind the danger that if we were not sufficiently definite

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about our conception of where the responsibility for a particular service lay, that service might not be provided by anyone. At the same time we would like to stress our agreement with the Royal Commission on the importance of co-operation among the various authorities concerned; this co-operation is one of the hallmarks of the schemes for community care in England about which we have heard, and we are sure that it is of great practical value. One positive move in the right direction would be the extension to mental illness of the Secretary of State's duty under section 49 of the National Health Service (Scotland) Act, 1947, to co-ordinate and supervise the exercise by local health and education authorities of their functions relating to mental deficiency; this extension might also cover all the authorities concerned.

6. There is one general point that we would like to make about local authority services. We recognise that there are certain services which it may be difficult for one authority to provide on their own, but we hope that authorities will, where it is necessary or desirable, exercise their powers under section 119 of the Local Government (Scotland) Act, 1947, to combine for any purpose in which they are jointly interested.

7. Various authorities already have clearly defined functions—in the form either of duties or of powers—in the field of community care of the mentally handicapped. We do not recommend the change of any existing duty to a power. In respect of all functions other than those which are already duties we had a choice of recommending one of three possible courses for the future:

(*a*) that the functions should take the form of permissive powers;
(*b*) that the functions should take the form of duties; and
(*c*) that the functions should take the form of permissive powers and that it should be open to the Secretary of State to direct at any time that particular functions are to become duties of particular authorities.

8. We have chosen the third course, and have done so for two reasons. These are, firstly, that it is in line with the existing provisions of Part III of the National Health Service (Scotland) Act, 1947 (which cover a number of the functions in question) and with those of the new Mental Health Bill for England and Wales; and, secondly, that it takes account of geographical circumstances: while it may be necessary and practicable to provide a certain service in a populous urban area, circumstances may make this impossible or impracticable in a remote rural area.

9. There is at present doubt about the adequacy of the powers of local health authorities and hospital authorities to provide certain services, and in the appropriate sections of our report we point out the need to define more clearly the powers necessary for the provision of the services in question. These powers could of course, like others, become duties at the Secretary of State's discretion.

10. We think it may be helpful to set out in tabular form in the first instance the community services which we think are needed for the mentally disordered and to show which, in our view, are the proper concern of particular authorities. This table constitutes a summarised preview of the narrative which follows it. The functions marked with an asterisk are those which are beyond doubt existing statutory powers or duties of the authorities concerned; the subsequent narrative indicates which are powers and which are duties. Each section of the table indicates at what point in the narrative the material relative to the section is to be found.

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11. Functions of local health authorities

Mental Illness	*Mental Deficiency*
(1)	Ascertainment except in relation to (*a*) children in attendance at school and (*b*) those between 2 and 5 whose parents request it from an education authority (paragraph 16).
(2)	*Facilities (including accommodation, equipment and staff) for diagnostic and advisory clinics in which Regional Hospital Board specialist services would also be provided (paragraph 17).
(3)*Care of and advice in respect of patients living at home (paragraphs 18-19).	Supervision of and advice on defectives living at home or boarded-out (paragraphs 18-19).
(4)*Arrangements for placing in guardianship (paragraph 20).	*Arrangements for placing in guardianship (paragraph 20).
(5) Guardianship (paragraph 21).	Guardianship (paragraph 21).
(6)	Care, training and occupation (at home, at a special day nursery, or at a training and occupation centre) for children not within the ambit of the education authority and not in hospital (the education authority no longer to be responsible for occupation centres) (paragraphs 22-29).
(7)	*Care, training and occupation (at home or at a trainiug and occupation centre) for defectives over the age of 16 who are not in hospital (paragraphs 22-29).
(8) Health services for children not at school (e.g., dental treatment and welfare milk) (paragraph 30).	Health services for children not at school (e.g., dental treatment and welfare milk) (paragraph 30).
(9)*Arrangements where appropriate for admission to hospital by compulsory procedure (paragraph 31).	*Arrangements where appropriate for admission to hospital by compulsory procedure (paragraph 31).
(10) Appointment of Mental Welfare Officers (paragraph 32).	Appointment of Mental Welfare Officers (paragraph 32).
(11)*Sheltered workshops under Disabled Persons (Employment) Act, 1958 [a] (paragraph 33).	*Sheltered workshops under Disabled Persons (Employment) Act, 1958 [a] (paragraph 33).

[a] Present powers assigned to " the local authority ".

(12) Residential accommodation for persons not requiring admission to hospital, (a) by providing hostel accommodation; or (b) by contracting for places in hostel accommodation provided by another authority; or (c) by contracting with a voluntary body.	Residential accommodation for persons not requiring admission to hospital, (a) by providing hostel accommodation; or (b) by contracting for places in hostel accommodation provided by another authority; or (c) by contracting with a voluntary body.

(Residential accommodation provided for the above purpose may also be used for patients before entering or after leaving hospital) (paragraphs 34-40).

(13)*Any ancillary or supplementary services by way of community care (paragraph 41).	*Any ancillary or supplementary services by way of community care (paragraph 41).

12. Functions of education authorities

(1)*To provide special educational treatment by way of special schools, residential schools, hostels attached to day special schools, special classes or home teaching (paragraph 42).

(2)*To ascertain what children who have attained the age of five years require special educational treatment or are suffering from a disability of mind of such a nature or to such an extent as to make them unsuitable for special educational treatment, and to report accordingly to the local health authority; and to carry out ascertainment in children between 2 and 5 at the request of parents (paragraph 42).

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13. Functions of local welfare authorities

(1)*To provide residential care under section 21 of the National Assistance Act, 1948, for the senile infirm person whose senility does not require continuous nursing care or supervision (paragraph 43).

(2)*To provide welfare services for the mentally handicapped under section 29 of the National Assistance Act, 1948 (paragraph 44).

14. Functions of Regional Hospital Boards

Mental Illness	*Mental Deficiency*
(1)*Provision of specialist services (psychiatric and other) in connection with diagnosis and treatment.	*Provision of specialist services (psychiatric and other) in connection with ascertainment, and in particular at any diagnostic and advisory clinic provided by a local authority.
(2)*Day hospital and out-patient facilities, including clinics, for patients living in the community (paragraph 17).	*Day hospital and out-patient facilities, including clinics, for patients living in the community (paragraph 17).
(3)*Domiciliary visits by hospital specialists where the patient cannot come to an out-patient clinic.	*Domiciliary visits by hospital specialists where the patient cannot come to an out-patient clinic.
(4) Hostel accommodation for patients who need a period of trial before going back home or to lodgings (paragraph 45).	Hostel accommodation for patients who need a period of trial before going back home or to lodgings (paragraph 45).

15. We would like now to comment on the allocation of functions which we have made above, and on the functions themselves.

Local health authorities

Ascertainment

16. Section 54 of the Education (Scotland) Act, 1946, places a duty on education authorities to ascertain what children of 5 years old and over in their areas:

(*a*) require special educational treatment; or

(*b*) are suffering from a disability of mind of such a nature or to such an extent as to make them incapable of receiving education or training in a special school, or as to make it inexpedient that they should be educated or trained in association with other children.

This section also places a duty on education authorities to have medically examined, with a view to ascertainment, any child of 2 years old and over whose parents request this. We recommend that education authorities should retain their functions of ascertainment in relation to children at school and to children between 2 and 5 whose parents request it. Such requests from parents to education authorities are likely however to relate only to children in attendance at nursery schools, and we regard as very important the early ascertainment of all cases of mental deficiency. The question of ascertainment is closely related to that of diagnostic clinics, the initiative for the provision of which, we suggest in the next paragraph, should come from local health authorities; and we recommend that these authorities should have clearly-defined powers to carry out

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ascertainment in young children. We consider that good co-operation among all those concerned is essential if ascertainment is to be successful, and we would welcome any arrangements whereby this co-operation could be achieved. We regard co-operation between the Medical Officer of Health and the general practitioner as of particular importance.

Diagnostic and advisory clinics

17. The Report on Mental Deficiency in Scotland, published by the Scottish Health Services Council in 1957, contained a recommendation that the initiative for the organisation of mental deficiency clinics should rest with local authorities. We regard such clinics as having an important part to play in the diagnosis of mental deficiency and the giving of advice to patients, relatives and general practitioners. We would agree with the principle that the initiative should rest with local authorities, but the precise shape of the organisation that results from this initiative will inevitably vary according to geographical circumstances. In the large burghs and in districts of similar population a clinic provided by the local health authority, with specialist services provided by the Regional Hospital Board (as already organised in the Eastern Region) is a sound arrangement. In rural areas there may be a choice of examining children at a central clinic, at a local school clinic, at a hospital, at the family doctor's surgery, or by a domiciliary visit. Whatever arrangements are made, they should have a double purpose—the diagnosis of the child's condition and advice to the parents. We do not wish what we say above to be construed as preventing hospital authorities from running clinics in the future. In some localities and for some purposes this may be an excellent arrangement: on the basis, however, that primary responsibility in the matter should lie with local health authorities, we recommend that these authorities should be notified about patients dealt with at hospital clinics.

Care and advice in relation to patients at home or boarded-out

18. The Royal Commission mentioned general social work to help all types of mentally disordered patients and their relatives as one of the desirable features of a community service. We agree with this, and we were concerned to learn about the limited use being made by local health authorities of the powers of domiciliary visitation and after-care contained in the National Health Service (Scotland) Act, 1947. We had available to us the booklet on " The Handicapped Person " published by The Scottish Council of Social Service; the extracts from it reproduced as Appendix II to our report illustrate, in relation to mental defectives, the remarks which we have made above. The presence in a household of a mentally disordered person, whether young or old, can create difficult problems which inevitably impose a strain on relatives; we regard it as essential that they should not be left to cope with these problems alone, and that help and advice should be available to them if they need it and want it.

19. In relation to mental defectives we have used the term " supervision ". Section 30 of the Mental Deficiency Act, 1913, places a duty on local authorities in England and Wales to provide suitable supervision for mental defectives as a measure short of placing in guardianship or in an institution. The Mental Deficiency (Scotland) Act, 1913, makes no mention of supervision, but the White Paper on the Law relating to Mental Illness and Mental Deficiency in

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Scotland said that a number of defectives who do not need to be dealt with formally under the Mental Deficiency Acts would benefit from supervision by regular visits from appropriate officers of a local health authority or a voluntary organisation. It was accordingly proposed that local health authorities should have a duty to arrange such supervision where it was necessary or desirable, either at their own hand or through voluntary organisations. We too think that such a service would be valuable—in respect, for example, of the 700 mentally handicapped children who leave Scottish special schools and occupational centres yearly, and for only a limited proportion of whom senior occupational centres are available; we recommend that local health authorities should be given the necessary statutory powers.

Placing in guardianship

20. Local authorities in Scotland have in general made good use of their powers of placing in guardianship, and it is clear to us that these powers should be maintained.

Guardianship

21. We agree with the Royal Commission that local health authorities should themselves have power to act as the guardians of mentally disordered patients. We think it advisable to make clear that this need not mean in Scotland the elimination of the sheriff from the statutory procedure for placing in guardianship.

Care, training and occupation for mental defectives in the community

22. In our view local health authorities should be regarded as the authorities basically responsible for mental defectives in the community. Together with the general practitioner, they are the first people likely to obtain information about mental deficiency in a child, and it is important that continuity of care by them should be maintained. It is inevitable that there should be some interruption or change in responsibility in respect of defectives who enter hospital (which they may do at any age) or who enter the school system (which they may do at the age of 2 or—more probably—at the age of 5 or over); but local health authorities should have considerable responsibilities in respect of other defectives. These may be summarised thus:

(*a*) continuity of responsibility for defectives who at no stage are admitted to hospital or to the school system—this responsibility may include arrangements for hospital out-patient treatment; training and occupation at home, at a junior or senior training and occupation centre or at a special day nursery; or arrangements for home education provided by the education authority;

(*b*) responsibility for defectives who have ceased to be a hospital responsibility.

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23. The question to which we have given most attention under the general heading of "training and occupation" is that of training and occupation centres. We will begin by setting out the existing statutory position in Scotland.

24. Section 54(1) of the Education (Scotland) Act, 1946, places a duty on education authorities to ascertain what children in their areas who have attained the age of five years require special educational treatment, or are suffering from a disability of mind of such a nature or to such an extent as to make them incapable of receiving education or training in a special school or as to make it inexpedient that they should be educated or trained in association with other children. Special educational treatment may be provided in a special school, and special schools are defined as including, among other things, occupational centres. Section 56 of the 1946 Act provides that where an education authority decide that a child is incapable of receiving education or training in a special school (including an occupational centre) or that it is inexpedient that he should be educated in association with other children, they must make a report to that effect to the local health authority. Under section 51 of the National Health Service (Scotland) Act, 1947, local health authorities have a duty to provide or secure the provision of suitable training and occupation for (*a*) persons under the age of 16 who have been reported by the education authority as incapable of receiving education or training in a special school; and (*b*) mental defectives over the age of 16.

25. The effect of the provisions detailed in the preceding paragraph is that in Scotland both education authorities and local health authorities have a duty to provide training and occupation centres for certain categories of mental defectives. In England, on the other hand, the provision of such centres is a function of local health authorities only. We have been impressed by what we have heard about English schemes of community care. We believe these schemes to be more integrated and comprehensive than those existing in Scotland, and we think that this may well be due to the fact that England does not have dual responsibility. We have considered at some length what the future pattern in Scotland should be, and have finally reached the conclusion that in future the provision of both junior and senior training and occupation centres should be a duty of local health authorities in this country.

26. Before proceeding to give the arguments which have led us to make this choice we would like to make it plain that our conclusion carries with it no implied criticism of Scottish education authorities. We acknowledge the achievement of these authorities in providing some 30 junior centres since the Education (Scotland) Act, 1946, came into operation, and we are aware of the good work which is being done in these centres.

27. As we see them, the arguments in favour of local health authority responsibility are as follows:

(*a*) one authority—and that the best equipped to undertake it—would have continuity of responsibility for the mental defective from the time of ascertainment in the early years onwards throughout his life;

(*b*) there is a significant social and medical element in the training of defectives—and particularly of defective children unable to benefit from formal education in a special school—which makes the work appropriate to local health authorities as the bodies who in our view should be basically responsible for their community care;

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(*c*) local health authorities, if the scope of their activities were extended and their staff consequently increased, would be better equipped to deal with those difficult cases that are not clearly within the ambit of school, occupation centre (as at present provided by education authorities) or hospital —e.g., certain children who at present are excluded from centres because of the difficulties arising from associated physical handicap;

(*d*) local health authorities might be in a better position to extend their activities to cover school holidays, with resulting benefits to parents and children;

(*e*) there is no doubt even under existing legislation about local health authorities' powers to provide centres for defectives over 16, whereas it seems questionable whether this is a proper use of education authorities' further education powers.

28. We think it right to deal with the arguments which have been put forward in favour of the retention by education authorities of a duty to provide junior training and occupation centres. These are:

(*a*) education authorities have in fact already provided a significant number of junior centres in Scotland, whereas only one centre has been provided by a local health authority;

(*b*) the staff of junior centres can, under education authority control, be interlinked with those of special schools;

(*c*) upgrading and downgrading to and from special schools can be effected with ease under the present system;

(*d*) it is of some importance to parents for junior centres to be regarded as part of the school system.

On the first of these arguments, we have, in paragraph 26, recognised what education authorities have already achieved. To set the matter in perspective, however, it is necessary to mention two points—firstly, that education authorities have until recently enjoyed a more favourable rate of grant than local health authorities; and, secondly, that local health authorities' existing duty in respect of children between 5 and 16 confines them to catering for those found by education authorities to be incapable of receiving education or training in a special school, this including by definition an education authority occupational centre. We recognise that the easy transfer of children between special school and training and occupation centre is important, but we do not think that our proposal would impede this, and we are fortified in this view by what we have heard from the representatives of English authorities. The experience of these authorities also tends to support our view that the fourth argument is of rather less weight than it is believed to be by those in the education field.

29. If our recommendation on this matter is accepted, it will be necessary to make an appropriate extension to the existing statutory duty of local health authorities in respect of junior centres, and, as a corollary, to withdraw education authorities' duties. Local health authorities' existing duty under section 51 of the National Health Service (Scotland) Act, 1947, in respect of defectives over 16 appears adequate to cover the provision of senior centres. We would like to make it clear that we envisage compulsory attendance of children at local health authority junior centres during school terms, and voluntary attendance at other periods. Our final point is that, while we have spoken of mental defectives throughout this section, we would not wish to have kept out of a centre any mentally ill person who might benefit from attendance.

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Health Services for children not at school

30. The Royal Commission recommended that children of school age not attending school should not be deprived of the health services, such as medical and dental treatment and free milk, enjoyed by ordinary school schildren. With this we agree, and we consider that local health authorities should have power to implement this recommendation.

Arrangements for compulsory procedure

31. Local health authorities already have the necessary powers under this head: we would call attention to what we said in paragraphs 32, 37 and 38 of our previous report.

Mental Welfare Officers

32. At present there are in Scotland duly authorised officers appointed under statutory powers for the purposes of certification. We consider that there is a need for a type of officer working in a broader field of mental welfare; we envisage a layman with social service experience who would be responsible to the Medical Officer of Health for the day-to-day execution of the local health authority's community care functions. We agree with the Royal Commission that such officers might appropriately be called Mental Welfare Officers. A certain number of such officers are already employed in the Welfare Departments of local authorities; this means that we are suggesting a change in recommending that, in future, such officers should form part of the staff of local health authorities.

Sheltered workshops

33. Under the Disabled Persons (Employment) Act, 1958, local health authorities have a power to provide sheltered workshops, and may be directed by the Minister of Labour and National Service to provide them for persons resident in their area. We are disappointed that sheltered workshops in Scotland have not made a significant contribution to the problem of the mentally handicapped in Scotland, but did not think it appropriate for us to investigate the reasons for this.

Residential accommodation

34. We have given a good deal of thought to the application to Scotland of those recommendations of the Royal Commission that deal with the provision of residential accommodation for the mentally disordered. We think that there is less need for such accommodation in Scotland than the Royal Commission seemed to think there was in England and Wales. We have considered the likely needs of both the mentally ill and the mentally defective; we have divided both groups into three categories, and we deal first with the mentally ill.

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Mentally Ill

35. The three categories of mentally ill patients whom we have considered are as follows:

(*a*) persons of working age who can be treated as out-patients or day patients, but who need to live during treatment in the supportive atmosphere of a hostel rather than in their own homes or in lodgings;

(*b*) persons of working age leaving hospital who need a " half-way house " before returning to live at home or in lodgings;

(*c*) elderly mentally infirm patients who may or may not have been in hospital.

36. There is evidence that there is at present less demand in Scotland than in England for residential accommodation for people in the first two categories. The day may come, however, when the demand is greater than we believe it to be now, and we recommend that there should be power to provide hostels for patients in these categories. The first category seems to us a responsibility appropriate to local health authorities, but they should be able to contract with voluntary associations for the provision of the accommodation—this, we believe, is done in certain parts of England. As we indicate later, we regard the second category as a responsibility appropriate to hospital authorities.

37. We consider, on the other hand, that there is an established need in Scotland for hostels for elderly mentally infirm people, and we develop later our recommendation that the provision of hostels for such people should he a duty of local welfare authorities.

Mental Defectives

38. The three categories of patients with whom we are concerned under this heading are as follows:

(*a*) children who do not require admission to a mental deficiency hospital and for whom supervision in their own homes or under guardianship seems unsuitable;

(*b*) school leavers and young adults who present employment and behaviour problems and who cannot be supervised by the local authority while living at home or under guardianship but who do not need admission to a mental deficiency hospital;

(*c*) mentally defective patients from hospital who cannot he sent straight home or immediately placed under guardianship.

39. We have reached the conclusion that for the majority of children in the first category it would be preferable for education authorities to expand the provision of residential special schools or hostels attached to day special schools rather than for other authorities to provide hostels; such schools could provide, through teachers properly qualified for the job, the kind of training and education appropriate to the capacity of the children concerned. For the remainder—those of the first category who are ineducable—the best arrangement in our view would be the provision by local health authorities of hostels attached to training and occupation centres if there were sufficient demand.

40. We believe that there is a need in Scotland for hostels to accommodate people in the second two categories, on the lines of hostels provided in certain areas in England. We believe that, according to different circumstances in different localities, there is room for experiment in the provision of such hostels both by local health authorities and by hospital authorities; we suggest that, on

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balance, hostels for category (*b*) are a responsibility proper to local health authorities, and that hostels for category (*c*) should be provided by hospital authorities. It is important in relation to the half-way houses that continuity of treatment should be maintained; for this reason, hospital medical staff should have free access to ex-patients who may be accommodated in a local authority hostel. It is equally important that half-way houses should so far as possible be placed near to sources of employment.

Ancillary or Supplementary Services

41. This heading covers a wide range of work for the mentally disordered in the community. We consider that generally the local health authority should take the initiative in assessing the total amount of work to be done in any particular area, but there should be the closest co-operation between them and the hospital authorities. With this objective in view, we consider that there is much to be said for the arrangement which we believe obtains in certain areas in England whereby mental welfare officers, psychiatric social workers and other social workers are appointed by one authority but work also in the field of another. Hospital authorities should certainly see to it that the fullest use is made, where this can be done advantageously, of the facilities provided by the local health authority for patients leaving hospital. We think that those patients who would benefit from community care after discharge would often be more ready to accept it if the initial contact with the local health authority were made before they left hospital. We would welcome an extension of this system.

Education authorities

42. We have indicated above the functions in respect of ascertainment and of training and occupation centres that we consider appropriate to local health authorities. We think it proper for education authorities to retain the functions which we have mentioned in the table.

Local welfare authorities

43. In paragraph 37 we mentioned the question of residential accommodation for the elderly mentally infirm who do not require continuous nursing care or supervision. The number of such elderly people is likely to increase, and we think that local welfare authorities should have regard to this fact in the discharge of their duties under section 21 of the National Assistance Act. The Department of Health for Scotland have suggested to local authorities and hospital authorities certain criteria by which a division of responsibility for the care of the elderly sick can be achieved. These criteria are reproduced as Appendix III to this report; they are applicable to the elderly mentally infirm as well as to other elderly people.

44. The Department of Health for Scotland have already brought to the notice of local welfare authorities the welfare needs of the mentally handicapped, and we too would encourage the use of existing powers in order to meet these needs. We recommend that consideration be given in Scotland to the recommendation of the Royal Commission that local authorities should have freedom to use health or welfare powers without any restriction such as is at present contained in the National Assistance Act, 1948.

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45. The only new power which we are suggesting is that to provide hostel accommodation for in-patients who need a period of trial before going back home or to lodgings.

Conclusion

46. The degree of emphasis which we have placed on the various aspects of community care of the mentally disordered has not always been the same as in the case of the Royal Commission, but our recommendations are substantially in line with theirs, and indeed differ from them only in one main respect. While the Royal Commission recommended that community care should be a positive duty on local authorities, we have concluded that, except in respect of existing duties, the future functions of local authorities should take the form of powers that can become duties if the Secretary of State so decides. We think it right to say, however, that we decided in favour of powers rather than of duties only after prolonged and careful consideration, and with some hesitation.

47. The principal legislative change which we are recommending is that in Scotland junior and senior training and occupation centres should in future be the responsibility of local health authorities only. The effect of this would be that junior occupation centres at present provided by education authorities would be transferred to local health authorities; that local health authorities would provide additional centres required in future; and that the statutory position in respect of senior centres would be clarified. This is a change which in our view is necessary if local health authorities are, as we hope, to have generally a more active role in the future in regard to mental defectives in the community and to have more clearly placed on them the onus of continuous responsibility for mental defectives of all ages who are not at school and not in hospital.

48. Some of the developments which we envisage may take some time to carry through, but nevertheless there are three which in our opinion could be effected at an early date and without difficulty, namely (*a*) the provision of health services of the kind mentioned in paragraph 30 for mentally ill and mentally defective children not at school; (*b*) the provision of further clinics for the diagnosis of mental deficiency; and (*c*) intimation by hospital authorities to local health authorities of cases of mental deficiency diagnosed in hospital clinics.

49. We wish to conclude by stressing that legislation by itself will not achieve all the objectives in the minds of the Royal Commission and with which we generally agree. Indeed such changes in legislation as we are recommending will not in themselves alter the present situation greatly, We hope to see an extension throughout Scotland of the enthusiasm and initiative shown by a limited number of local authorities in England and Scotland who, with the co-operation of the other authorities concerned, have achieved notable results. As a contribution to this end we suggest that the Department of Health for Scotland should give a clearer lead on policy for the development of the mental health service, and more support to the development itself; in this connection we think that the Department's mental health division might be appropriately strengthened.

50. Our report is unanimous, except in respect of the conclusion in paragraph 25, from which Dr. MacGillivray dissents.

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51. The Committee wish to record again, and in the same words as in their First Report but with no less emphasis, their appreciation of the assistance they have received from Mr. Taylor as Assessor and from Mr. Reid as Secretary. They have both helped very materially in marshalling and focusing the considerations to be taken into account by the Committee and Mr. Reid has had a difficult task in preparing drafts of the Report following discussions which inevitably covered a wide range of topics.

JOHN DUNLOP
Chairman
(on behalf of the Committee)

February, 1959.

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APPENDIX I

(Paragraph 3 of Report)

Persons who appeared before the Committee

MR. J. SQUIRE HOYLE, M.B.E., Executive Officer, Mental Health Services Department, Leeds.

DR. C. W. J. INGHAM, Principal Medical Officer, Public Health Department, London County Council.

DR. J. T. CHALMERS KENDIE, Medical Officer of Health, Oldham.

MR. T. P. MCKNIFF, Lay Administrative Officer, Public Health Department, Oldham.

MR. J. F. MONTGOMERIE, I.S.O., D.C.M., Social Research Officer, Scottish Council of Social Service.

MR. JOHN A. SMITH, M.A., B.ED., Depute Director of Studies, Jordanhill Training College.

MISS BARBARA S. WATSON, M.A., Superintendent of Schools of Handicapped Children, Glasgow.

MR. W. M. MORRISON, O.B.E., Scottish Education Department.

MR. D. R. MCFARLANE, Scottisb Education Department.

H.M.I. MR. J. A. MCPHERSON, Scottish Education Department.

APPENDIX II

(Paragraph 18 of Report)

Extract from " The Handicapped Person "

" Unless a child is certified as a mental defective, there is no regular visitation or after care. Some 14 Local Authorities stated that visits were made by their officers. In another eight areas the local Association for Mental Welfare undertook visitation of children in their homes. In Stranraer and Clydebank, the local Mental Welfare Associations established Junior Occupation Centres. In Glasgow, Airdrie, Sanquhar and Castle Douglas, the local branches of the Scottish Association of Parents of Handicapped Children established Junior Centres.

After-care for the mentally handicapped person over 16 is rather limited. Tbirty-two Local Authorities make no provision for domiciliary visitation. In Dundee and Glasgow the Local Authority has appointed a designated After-Care Officer whose duty is to provide a link-up with the Education Authority in respect of all leavers from occupation centres and special schools. These officers are members of the Health and Welfare Department and work under the direct control of the Medical Officer of Health. They are, however, not responsihle for the certified mental defectives under guardianship. Registers are compiled from lists supplied by the Education Authority and regular domiciliary visitation is undertaken. There is co-operation with the Youth Employment Officers in placing the mentally handicapped in employment. Persons are removed from the register at 21 years of age or earlier on marriage. In eight cases, the Local Authority undertakes responsibility for domiciliary visitation and this is generally done by the Welfare Officer, District Officer, Health Visitor, District Nurse, or in one or two instances by a Social Worker. In 13 areas domiciliary visitation is done by voluntary organisations."

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APPENDIX III

(Paragraph 43 of Report)

Division of responsibility for Care of the Elderly Sick

A. HOSPITAL AUTHORITIES

Apart from the acute sick and others needing active treatment, who clearly require hospital admission, the responsibility of the hospital authorities normally covers—

(i) those who require more or less continuous nursing care or supervision, whether they need medical treatment or not;

(ii) continued care of the elderly sick who have completed active treatment but who still require rehabilitation in hospital or for some other reason are not yet ready for discharge to their own homes or to a Welfare Home;

(iii) care of senile, confused or disturbed patients who cannot, owing to their condition, live a normal community life in a Welfare Home;

(iv) care of the person (accidents apart) who has lost control of bowels or bladder.

The hospital authority cannot be expected to be responsible for providing all medical or nursing care needed by elderly persons, however minor the illness or however short the stay in bed.

B. WELFARE AUTHORITIES

The elderly person who is in need of care and attention which he cannot be given at home or be expected to obtain for himself elsewhere in the community, is a responsibility of the welfare authority, who should undertake also—

(i) care of residents in a Welfare Home during minor illnesses which may involve a short period in bed but not medical or nursing care beyond what is normally undertaken by the general practitioner and district nurse in a patient's own home;

(ii) care of the infirm old person who may need help in dressing, toilet, etc., and may need to live on the ground floor because he cannot manage stairs; this will include the senile whose senility does not require continuous nursing care or supervision;

(iii) care of the resident who is not expected to live more than a few weeks in circumstances where if in his own home he would have stayed there, e.g., because he cannot benefit from treatment or nursing care beyond what could be given to him at home.

All these are persons for whom any necessary nursing care would be given by relatives with the help or advice of the district nurse if they were living in their own homes. In Welfare Homes care of this kind is given by the staff with the help, where necessary, of the domiciliary nursing service.

The authority cannot be expected to be responsible for giving prolonged nursing care to the bedfast but Welfare Homes over the next decade should concentrate rather, it is suggested, on the frail.

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